IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

December 30, 2008

Merinda Halladay
Belmont Care Center
3625 Vaughn Street
Pocatello, ID 83204

RE: Belmont Care Center, Provider #13G046

Dear Ms. Halladay:

This is to advise you of the findings of the Medicaid/Licensure survey of Belmont Care Center, which was conducted on December 18, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **January 12, 2009,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by January 12, 2009. If a request for informal dispute resolution is received after January 12, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

Jim Truesdell for
MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G046	A. BUILDING _____ B. WING _____	12/18/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT CARE CENTER	3625 VAUGHN STREET POCATELLO, ID 83204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey. The surveyors conducting the survey were: Michael Case, LSW, QMRP, Team Leader Jim Troutfetter, QMRP Common abbreviations used in this report are: HRC - Human Rights Committee IPP - Individual Program Plan PTSD - Post Traumatic Stress Disorder QMRP - Qualified Mental Retardation Professional	W 000	**Preparation and implementation of this plan of correction does not constitute admission or agreement by Belmont Management with the facts, findings, or other statements as alleged by the Bureau of Facility Standards dated December 18, 2008. Submission of this plan of correction is required by law and does not evidence the truth of some of the findings as stated by the survey agency. Belmont Management specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action.**	
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on review of the facility's policies and procedures and staff interview, it was determined the facility failed to adequately develop policies necessary to protect individuals from abuse, neglect and/or mistreatment by the Administrator for 15 of 15 individuals (Individuals #1 - #15) residing at the facility. This resulted in the potential for individuals to be unprotected from abuse, neglect and/or mistreatment. The findings include: 1. The facility's Abuse, Neglect, Mistreatment and Injuries of an Unknown Source policy, revised 1/30/04, did not include procedures to be followed if the Administrator was the person accused of abuse. Therefore, the policy did not identify who	W 149	**POC W149 483.420(d)(1)** **STAFF TREATMENT OF CLIENTS** If the Administrator is accused of Abuse, Neglect, or Mistreatment, the responsibility to investigate and perform the duties assigned to the Administrator will fall upon the Regional Director. This would include but is not limited to, immediate notification, immediate action to protect from further abuse, ability to suspend staff, and reporting to appropriate agencies. This will be stated in Belmont Managements Abuse, Neglect, Mistreatment and Injuries of Unknown Source policy. Training will be given to staff in the bi-annual Abuse training on the changes in this policy. Person Responsible: Regional Director and Administrator	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M. Hallock — TITLE: Administrator — (X6) DATE: 1/9/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 149	Continued From page 1 was responsible to perform the duties assigned to the Administrator as the result of an abuse, neglect, or mistreatment allegation. Those duties included, but were not limited to, immediate notification, immediate action to protect from further abuse, ability to suspend staff, and reporting to appropriate agencies. When asked during an interview on 12/16/08 at 2:31 p.m., the Administrator stated the policy did not include procedures to be followed if the Administrator was the person accused of abuse. The facility failed to ensure the Treatment of Clients/Residents policy included instructions to follow if the Administrator was the staff accused of abuse, neglect, and/or mistreatment.	W 149	Monitor: Training will be completed on a bi-annual basis with all staff. During this training staff will be instructed on when the administrator is accused. The Regional Director will review quarterly all allegations.	2/18/09
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the human rights committee for 1 of 4 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior approvals of restrictive interventions. The findings include: 1. Individual #1's 8/12/08 IPP stated he was a 23	W 262	**POC W262 483.440(f)(3)(i) PROGRAM MONITORING & CHANGE** Belmont will ensure that the Human Rights Committee reviews, approves, and assists in monitoring individual programs or medications designed to assist in managing inappropriate behavior or any programs that involve risk to their protection and rights. We will review all previous restrictive interventions to ensure that they have been reviewed, and current approval has been given. All documentation will be collected and in order prior to the implementation of the restrictive medications or programming. Notes will be taken during all of the Human Rights Committee meetings to document the topics of the discussion and any approval given by the committee. The informed consent documents will be revised to include not only the acknowledgement of the	

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W 262	Continued From page 2 year old male whose diagnoses included PTSD, schizoaffective disorder, and mild mental retardation. His IPP stated he was committed to the Department of Health and Welfare and had a court appointed representative through the Department. His Physician's Orders, dated 11/08, stated he received Prozac (an antidepressant drug) 40 mg daily, Abilify (an antipsychotic drug) 10 mg daily, Wellbutrin (an antidepressant drug) 200 mg daily, and Lithium (a central nervous system drug) 450 mg twice daily. a. Individual #1's record contained a Written Informed Consent for Prozac, dated 9/22/07, signed by the HRC. The consent expired 9/22/08. When asked about the approval during an interview on 12/18/08 from 8:00 - 8:45 a.m., the Behavior Specialist stated he believed the approval had been renewed in 8/08 but could not find the documentation. The Behavior Specialist stated he did not have notes regarding the HRC meeting and discussion or approval of the drug for Individual #1. The facility failed to ensure HRC approval for Individual #1's Prozac was obtained prior to the continued use of the drug. b. Individual #1's record did not contain HRC approval for the use of Abilify. When asked about the approval during an interview on 12/18/08 from 8:00 - 8:45 a.m., the Behavior Specialist stated he believed the approval had been obtained when the drug was started in 9/08 but could not find the documentation. The Behavior Specialist stated	W 262	**Human Rights Committee but also the Behavior Specialist, Nurse, QMRP, and the Administrator.** **Person Responsible: Behavior Specialist, LPN, QMRP, and Administrator** **Monitor: The informed consent will be revised to include the acknowledgement and signature of not only the Human Rights Committee but also the LPN, Behavior Specialist, QMRP, and Administrator prior to the implementation of the restrictive programming or medication. A checklist will be kept, providing documentation on when consents were obtained and will be reviewed during the monthly behavior meetings.**	2/18/09

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W 262	Continued From page 3 he did not have notes regarding the HRC meeting and discussion or approval of the drug for Individual #1. The facility failed to ensure HRC approval for Individual #1's Abilify was obtained prior to the implementation of the drug.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the parent/guardian for 1 of 4 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior approvals for restrictive interventions. The findings include: 1. Individual #1's 8/12/08 IPP stated he was a 23 year old male whose diagnoses included PTSD, schizoaffective disorder, and mild mental retardation. His IPP stated he was committed to the Department of Health and Welfare and had a court appointed representative through the Department. His Physician's Orders, dated 11/08, stated he received Prozac (an antidepressant drug) 40 mg daily, Abilify (an antipsychotic drug) 10 mg daily, Wellbutrin (an antidepressant drug) 200 mg daily, and Lithium (a central nervous system drug) 450 mg twice daily.	W 263	**POC W263 483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE** Belmont will ensure that the Advocate, Guardian, or the consumer reviews, approves, of individual programs or medications designed to assist in managing inappropriate behavior or any programs that involve risk to their protection and rights. We will review all previous restrictive interventions to ensure that they have been reviewed, and current approval has been given. All documentation will be collected and in order prior to the implementation of the restrictive medications or programming. The informed consent documents will be revised to include not only the acknowledgement of the Advocate, Guardian an/or the consumer but also the Behavior Specialist, Nurse, QMRP, and the Administrator. This will assist to ensure that all documents are in place prior to implementation of the programming or medication. Person Responsible: Behavior Specialist, LPN, QMRP, and Administrator	

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W 263	Continued From page 4 a. Individual #1's record contained a Written Informed Consent for Prozac, dated 9/22/07, signed by Individual #1's court appointed representative. The consent expired 9/22/08. When asked about the consent during an interview on 12/18/08 from 8:00 - 8:45 a.m., the Behavior Specialist stated he believed the consent had been renewed in 8/08 but could not find the documentation. During a telephone interview on 12/18/08 from 10:50 - 11:00 a.m., Individual #1's court appointed representative stated he had not received a request to renew Individual #1's consent for Prozac. The facility failed to ensure consent for Prozac was obtained from Individual #1's court appointed representative prior to the continued use of the drug. b. Individual #1's record did not contain a consent for the use of Abilify. When asked about the consent during an interview on 12/18/08 from 8:00 - 8:45 a.m., the Behavior Specialist stated he believed the consent had been obtained when the drug was started in 9/08 but could not find the documentation. During a telephone interview on 12/18/08 from 10:50 - 11:00 a.m., Individual #1's court appointed representative stated he was not aware Individual #1 was taking Abilify. The facility failed to ensure consent for Abilify was	W 263	Monitor: The informed consent will be revised to include the acknowledgement and signature of not only the Advocate, Guardian and or consumer but also the LPN, Behavior Specialist, QMRP, and Administrator prior to the implementation of the restrictive programming or medication. A checklist will be kept, providing documentation on when consents were obtained and will be reviewed during the monthly behavior meetings.	2/18/09

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W 263	Continued From page 5 obtained from Individual #1's court appointed representative prior to the implementation of the drug.	W 263		
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of individual's IPPs that were directed specifically towards the reduction and eventual elimination of the behaviors for which the drugs were employed for 3 of 3 individuals (Individuals #1, #2, and #4) reviewed, who received behavior modifying drugs. This resulted in individuals receiving behavior modifying drugs without plans that identified the drug usage and how they may change in relation to progress or regression. The findings include: 1. Individual #1's 8/12/08 IPP stated he was a 23 year old male whose diagnoses included PTSD, schizoaffective disorder, and mild mental retardation. His Physician's Orders, dated 11/08, stated he received Prozac (an antidepressant drug) 40 mg daily, Abilify (an antipsychotic drug) 10 mg daily, Wellbutrin (an antidepressant drug) 200 mg daily, Lithium (a central nervous system drug) 450 mg twice daily, and Melatonin (an herbal sleep drug) 3 mg daily.	W 312	**POC W312 483.450(e)(2) DRUG USAGE** Belmont will ensure that medications used for the control of inappropriate behavior will be used as an integral part of the client's individual program plan that is directed specifically towards the reduction of and possible elimination of the behaviors for which the drugs are employed. The consumer will have a program in place for each of the medications that are being used for the control of inappropriate behavior. Belmont will review all medication reduction plans to ensure that correct information is present and that each of the required sections on the medication reduction plan is completed with specific information concerning the reduction plan. We will ensure that each required section on the reduction plan will be completed in a flow chart format and that each part is clearly defined with specific guidelines for reduction. The Medication Plan will define one of each of the following diagnosis, symptom, treatment plan, and objective criteria for each medication. In addition, individuals with multiple medications will have the order of reduction noted in their plans. These Reduction plans will be monitored through the data collected in the programs designed to manage the specific	

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W 312	Continued From page 6 a. Individual #1's Psychotropic Medication Plan for Prozac, dated 2/11/04, included the following criteria to reduce the drug: - As per state regulations. - Individual #1 experienced severe, adverse side effects to the drug. - The treatment team, in coordination with the physician and HRC decided to increase other types of therapy while decreasing the drug. - The physician felt the drug could be decreased and still maintain a therapeutic level. The plan did not state how the use of the drug may change in relation to Individual #1's psychiatric signs and symptoms. When asked during an interview on 12/18/08 from 8:00 - 8:45 a.m., the Behavior Specialist and QMRP both stated criteria for reduction based upon Individual #1's psychiatric signs and symptoms was not included in the plan but should have been. b. Individual #1's Psychotropic Medication Plan for Wellbutrin, dated 10/22/07, included the following criteria to reduce the drug: - As per state regulations. - Individual #1 experienced severe, adverse side effects to the drug. - The treatment team, in coordination with the physician and HRC decided to increase other types of therapy while decreasing the drug. - The physician felt the drug could be decreased and still maintain a therapeutic level. The plan did not state how the use of the drug may change in relation to Individual #1's psychiatric signs and symptoms. When asked during an interview on 12/18/08 from 8:00 - 8:45	W 312	inappropriate behavior, monthly behavioral summaries, during monthly behavioral meetings, and quarterly with the psychiatrist. Person Responsible: Behavior Specialist, LPN, QMRP(s) and Administrator Monitor: These Reduction plans will be monitored through monthly behavioral summaries, during monthly behavioral meetings, and quarterly with the psychiatrist. In addition, the Behavior Specialist, QMRP(s), LPN, and Administrator will review monthly the status of the consumer and the criteria for reduction or change.	2/18/09

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W 312	Continued From page 7 a.m., the Behavior Specialist and QMRP both stated criteria for reduction based upon Individual #1's psychiatric signs and symptoms was not included in the plan but should have been. c. Individual #1's Psychotropic Medication Plan for Melatonin, undated, included the following criteria to reduce the drug: - As per state regulations. - Individual #1 experienced severe, adverse side effects to the drug. - The treatment team, in coordination with the physician and HRC decided to increase other types of therapy while decreasing the drug. - The physician felt the drug could be decreased and still maintain a therapeutic level. The plan did not state how the use of the drug may change in relation to Individual #1's sleep. When asked during an interview on 12/18/08 from 8:00 - 8:45 a.m., the Behavior Specialist and QMRP both stated criteria for reduction based upon Individual #1's sleep was not included in the plan but should have been. d. Individual #1's Psychotropic Medication Plans for Prozac, dated 2/11/04, Wellbutrin, dated 10/22/07, and Abilify, dated 9/3/08, each stated the drugs were used for the diagnoses of PTSD and schizoaffective disorder exhibited by depressive signs and symptoms. None of the plans indicated which drug would be targeted for reduction first, second, or third. When asked during an interview on 12/18/08 from 8:00 - 8:45 a.m., the Behavior Specialist and QMRP both stated the plans did not include an order of reduction for the drugs.	W 312		

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W 312	Continued From page 8 The facility failed to ensure behavior modifying drugs were used only as a comprehensive part of Individual #1's IPP that was directed specifically towards the reduction and eventual elimination of the behaviors for which the drugs were employed. 2. Individual #2's 7/1/08 IPP stated he was a 25 year old male whose diagnoses included mild mental retardation and Fetal Alcohol Spectrum Disorder. Individual #2's Psychotropic Medication Plan for Melatonin, dated 8/1/08, stated he received Melatonin (an herbal sleep drug) 6 mg daily to assist with sleep. The Psychotropic Medication Plan included the following criteria for the reduction of the drug: - When Individual #2 slept six out of seven nights for a total of seven hours per night for a period of one month. When asked about sleep tracking during an interview on 12/18/08 from 8:00 - 8:45 a.m., the Behavior Specialist stated staff tracked if Individual #2 was asleep during the grave-yard shift (10:30 p.m. - 6:30 a.m.), but the documentation was not tallied. The Behavior Specialist stated the information presented to the physician was based upon behavior reports received indicating Individual #2 was up during the night, but actual hours of sleep were not being reported to the physician. Additionally, the Behavior Specialist stated Individual #2's sleep on other shifts was not tracked other than on behavior reports and this data was not tallied. Without tracking actual hours of sleep for	W 312		

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W 312	Continued From page 9 Individual #2, it would not be possible for him to meet the criteria of seven hours per night for six out of seven nights for one month to have the medication reduced. The facility failed to ensure Melatonin was used only as a comprehensive part of Individual #2's IPP that was directed specifically towards the reduction and eventual elimination of the behavior for which the drug was employed. 3. Individual # 4's 7/8/08 IPP stated he was a 39 year old male whose diagnoses included schizophrenia paranoid type, PTSD, mild mental retardation. Individual #4's Psychotropic Medication Plan for Prozac (an antidepressant drug), dated 8/31/04, included the following criteria to reduce the drug: -Individual #4's self-injurious behaviors decrease below baseline for three consecutive months. However, the baseline for Individual #4 was zero incidents of self-injurious behavior per month. When asked during an interview on 12/18/08 from 8:00 - 8:45 a.m., the Behavior Specialist stated the criteria should have been zero for 3 consecutive months. The facility failed to ensure Prozac was used only as a comprehensive part of Individual #4's IPP that was directed specifically towards the reduction and eventual elimination of the behavior for which the drug was employed.	W 312		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least	W 440		

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W 440	Continued From page 10 quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure evacuation drills were conducted quarterly for each shift for 15 of 15 individuals (Individuals #1 - #15) residing in the facility. This resulted in the potential for the facility and staff not being able to determine individuals' responses nor identify problem areas. The findings include: 1. During a review of the facility's evacuation drills on 12/17/08, the following was noted: - There was no evacuation drill completed during the third quarter (July, August, September) for the grave-yard shift (10:30 p.m. - 6:30 a.m.). - There was no evacuation drill completed during the forth quarter (October, November, December) for the P.M. shift (2:30 - 10:30 p.m.). When asked during an interview on 12/18/08 from 8:00 - 8:45 a.m., the Administrator stated the drills could not be found and she was unable to confirm they had been completed. The facility failed to ensure evacuation drills were conducted at least quarterly on all shifts.	W 440	**POC W440 483.470(i)(1)** **EVACUATION DRILLS** Belmont will ensure that quarterly fire drills are completed and documented. The fire drills will be documented on the Care Tracker Kiosks. To ensure that Belmont is current on their fire drills, a drill will be run on each shift each month until they can be separated out back into the quarters. Person Responsible: Maintenance Supervisor, Home Supervisor, and Administrator Monitor: The Maintenance Supervisor and home supervisors will run the fire drills quarterly. They will complete the drills on the Kiosks. Reports will be pulled monthly and checked by the Administrator to ensure the drills were run.	2/18/09

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G046	A. BUILDING _____ B. WING _____	12/18/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT CARE CENTER	3625 VAUGHN STREET POCATELLO, ID 83204

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MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W149.	MM177	**POC MM177 16.03.11.075.09 Protection from Abuse and Restraint** Refer to Response W149 RECEIVED JAN 12 2009 FACILITY STANDARDS	2/18/09
MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194	**POC MM194 16.03.11.075.10(a) Approval of Human Rights Committee** Refer to W262	2/18/09
MM196	16.03.11.075.10(c) Consent of Parent or Guardian Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196	**POC MM196 16.03.11.075.10(c) Consent of Parent or Guardian** Refer to W263	2/18/09
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by:	MM197	**POC MM197 16.03.11.075.10(d) Written Plans** Refer to W312	2/18/09

Bureau of Facility Standards

M. Hallsley — Administrator — 1/9/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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MM197	Continued From page 1 Refer to W312.	MM197		
MM271	16.03.11.100.04(b) Storage of Toxic Chemicals All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all toxic chemicals were stored under lock and key for 15 of 15 individuals (Individuals #1 - #15) residing in the facility. The findings include: 1. An environmental review was conducted on 12/17/08 from 9:55 - 10:30 a.m. At that time, the following toxic chemicals were noted to be unlocked or accessible through the dispensing unit: - 1 bottle of disinfectant/sanitizer which was locked. However, the chemical could be accessed through its dispensing tube. - 1 bottle of Super Concentrated Bathroom Cleaner. However, the chemical could be accessed through its dispensing tube. - 1 bottle of Super Concentrated Citrus Degreaser. However, the chemical could be accessed through its dispensing tube. Additionally, in an unlocked cabinet in the laundry room were 17 bottles of Organic Spot Remover. The Material Safety Data Sheets for the above chemicals stated all should be kept out of reach of children and gave specific instructions to contact a physician and/or poison control if ingested.	MM271	**POC MM271 16.03.11.100.04(b) Storage of Toxic Chemicals** The storage of the toxic chemicals that are locked on the wall will be covered in a locked box. The box will enclose the attached hoses to ensure they are not accessible to the consumers. The bottles in the unlocked cabinet will be moved to the supply closet where they can be stored under lock and key. Person Responsible: Maintenance Supervisor, Home Supervisor, Housekeeping Supervisor and Administrator Monitor: The Maintenance Supervisor and Housekeeping supervisor will complete on-site checks to daily to ensure toxic chemicals are under lock and key. The home supervisor will monitor daily to ensure that staff are locking up the chemicals after use. The administrator will complete weekly checks to ensure toxic chemicals are locked.	2/18/09

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MM271	Continued From page 2 When asked, the Administrator, who was present during the environmental review, stated the chemicals should be locked. The facility failed to ensure all toxic chemicals were stored in appropriate areas under lock and key.	MM271		
MM337	16.03.11.110.04(c) Fire Drills A minimum of twelve (12) unannounced fire drills must be held annually, irregularly scheduled throughout all shifts. In addition, a least one (1) drill per shift must be held on a Sunday or holiday. This Rule is not met as evidenced by: Refer to W440.	MM337	**POC MM337 16.03.11.110.04(c) Fire Drills** Refer to W440	3/18/09
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 1 of 15 individuals (Individuals #1 - #15) residing in the facility. The findings include: During an environmental survey conducted on 12/17/08 from 9:55 - 10:30 a.m., it was noted:	MM380	**POC MM380 16.03.11.120.03(a) Building and Equipment** 1. The screen for the window will be replaced. 2. The hole in the wall was repaired. 3. The section of unpainted plaster was painted. 4. A cover plate was put on the outside electrical outlet. Person Responsible: Maintenance Supervisor, Residential Home Supervisor, and Administrator	

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MM380	Continued From page 3 - Individuals #5's bedroom window was missing one screen. - There was a 3 inch by 3 inch hole in the wall by the door in Individual #10's bedroom. - There was one 8 inch by 6 inch section and four 3 inch by 3 inch sections of unpainted plaster on the wall by the closet in Individual #10's bedroom. - The outside electrical outlet by the office door was missing the cover plate exposing the wires.	MM380	**Monitor: Monthly facility inspections be completed by the Home Supervisor and Maintenance Supervisor. Quarterly the Administrator will complete facility inspections.**	2/18/09